BCSC

Boston Child Study Center

Expert Mental Health Treatment, Training & Research

Application Checklist:

1. Completed Application For Services (pages 1-3) ☐
2. Signed Consent for Services (page 4-8) ☐
3. Signed Consent for Release of Information (page 9) ☐
4. Signed Billing Agreement/Authorization (page 10) ☐

Please complete, sign, and return the following documents prior to the potential patient's initial consultation to Ashley Flynn by fax: (866) 496-3029 or email: AFlynn@bostonchildstudycenter.com

Boston Child Study Center

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Application for Services

Today's Date:_____

Potential Patient Information:

Patient Name: _____ Age: _____ Date of Birth: _____
Name Used (if different from above): _____ Pronouns Used: _____
Patient Phone: (_____) _____-_____ Patient Email: _____
Home Address: _____ City: _____ Zip:_____

Parent/Guardian Information (if applicable):

Parent 1 Name: _____ Profession: _____ Phone: (____)_____-_____Type: C/H/W
Email Address: _____ May we contact you over email? Y / N
Home Address (if different from patient):_____ City: _____ Zip:_____
Parent 2 Name: _____ Profession: _____ Phone: (____)_____-_____Type: C/H/W
Email Address: _____ May we contact you over email? Y / N
Home Address (if different from patient):_____ City: _____ Zip:_____
Parents' marital status: _____ If separated, are legal proceedings in process or anticipated: Y / N
Siblings and ages:_____
Additional family members/individuals living in the patient's home: _____
How were you referred to Boston Child Study Center?_____

Please describe the nature of the problem(s) for which the patient is pursuing services:

Symptoms (e.g., anxiety, depression, suicidal ideation): Onset: Triggers:

_____
_____
_____
_____
_____
_____
_____

Educational History:

Current School (if applicable):_____ Grade:_____
All Previous Schools and Dates of Enrollment: _____
_____
Has the patient had any special testing or tutoring? Y / N If yes, please indicate:
Reason for testing/ tutoring: Dates: Outcomes/ Recommendations:

_____
_____
Does the patient have or has the patient ever had an IEP or 504? _____ Other school-related concerns: _____
_____

Developmental History (please attach additional pages if needed):

Was the patient exposed to antibiotics, medications, alcohol, drugs, or tobacco in utero? Y / N If yes, please indicate:

_____

Was the patient's gestation a full 40 weeks? Y / N If not, please explain: _____

_____

Were there any complications during the pregnancy (e.g., fetal distress, emergency C-section, pre-eclampsia, nuchal cord)? Y /N If yes, please indicate: _____

Were any special services required at the time of the patient's birth (e.g., lights for jaundice, ICU care)? Y /N If yes, please indicate:

_____

Were there any concerns/ delays in feeding, sleeping, walking, talking, or motor skills? Y /N If yes, please indicate:

_____

_____

Did the patient participate in Early Intervention services? Y /N If yes, please indicate dates and reason: _____

_____

Describe the patient's social functioning as a toddler? _____

What concerns, if any, are there currently about the patient's ability to socialize/ get along with peers, adults, and family members?

_____

Please list major life events the patient has experienced (e.g., moving, parent change in work, change in school, deaths, births, divorce):

Date of Occurrence: Life Event: Patient's Response:

_____

_____

_____

Patient Medical History (please list all diagnoses and attach additional pages if needed):

Past:_____

Current:_____

Patient Mental Health History (please list all diagnoses and attach additional pages if needed):

Past:_____

Current:_____

Has the patient been hospitalized in the past for mental health reasons? Y /N If yes, please indicate:

Dates: Circumstances/Reason: Hospital/Program: Discharge Recommendations:

_____

_____

_____

_____

Has the patient received other psychological services for these or other problems? Y / N If yes, please indicate:

Dates: Type of Service: Response to Treatment: Name/Profession of Provider:

_____

_____

Does the patient have a history of traumatic experiences or abuse? Y / N If yes, please briefly describe/state the traumatic experience(s): _____

Does the patient have a history of self-injury? Y / N If yes, please describe: _____

Does the patient have a history of suicidal behaviors/attempts? Y / N If yes, please describe: _____

Does the patient have a history of substance abuse? Y / N If yes, please describe: _____

Past & Current Medications (please attach additional pages if needed):

Medication & Dose: Dates Taken: Problem Treated: Response: Name of Prescriber:

Family Medical History:

Are there any biological family members with medical conditions (e.g., cardiac, diabetes, cancer)? Y / N If yes, please describe:

Relationship to Patient: Medical Condition: Treatment/ Other Information:

Family Mental Health History:

Are there any biological family members with mental health conditions (e.g., anxiety, depression, schizophrenia, bipolar, learning disability, autism, ADHD, eating disorder, substance abuse)? Y / N If yes, please describe:

Relationship to Patient: Mental Health Condition: Treatment/ Other Information:

Has the patient known anyone who attempted or completed suicide? Y / N If yes, please explain: _____

Is there any legal history including past involvement with DCF? Y / N If yes, please describe: _____

This application will be reviewed within 7-10 business days by the clinical team at Boston Child Study Center to ascertain whether our practice is the best treatment match, after which time you will be contacted regarding the disposition. If you have any questions about completion of this form or our services, you may contact us at (617) 800-9610 or AFlynn@BostonChildStudyCenter.com.

CONSENT FOR SERVICES

Welcome to Boston Child Study Center (BCSC). This statement provides important information about the services provided by Boston Child Study Center, practice policies and procedures, and the patient's rights and responsibilities. Please read this document thoroughly and be sure to raise any questions or concerns with the patient's therapist as soon as is feasible.

Description of Practice:

Boston Child Study Center specializes in evidence-based treatment for anxiety, behavioral, and mood disorders. As such, the patient's therapist will make every effort to provide the most appropriate evidence-based interventions or will provide the necessary referral information if he/she is not able to provide such care personally. Boston Child Study Center does not discriminate against any individual on the basis of race, color, ethnicity, religion, sex, age, national origin, sexual orientation, or socioeconomic status.

Nature of Services:

Initially the potential patient and, if applicable, the patient's caregiver(s) will meet for an initial consultation, which may take place over one or more visits depending on the patient's needs and the discretion of the clinical team. This consultation will help determine the nature of the patient's symptoms, concerns, and difficulties, as well as whether the services provided by Boston Child Study Center are appropriate for the patient's needs. This initial appointment typically consists of meeting with a specialist in the area of concern and may also include an additional structured diagnostic assessment for the patient and, if applicable, caregiver(s) which may take up to three hours to administer. The goal of this process is to assess the patient's functioning including the ability to regulate emotions and behaviors, to gather past/current psychological functioning, past/current psychiatric treatment, as well as academic, social, and family functioning in order to determine the best course of treatment. If the patient has a current treatment provider, the BCSC therapist may ask for written consent to speak with that person if it is likely to help in making assessment or treatment decisions for care. The fee for this initial consultation is up to $450 per scheduled meeting.

After the consultation, the therapist will give feedback, make recommendations for further services, and describe various treatment options that may be the best fit for the patient's needs. If the patient is offered services through Boston Child Study Center, we will describe what will be required, what to expect in treatment, and address any concerns or questions. If the patient accepts treatment with Boston Child Study Center, a fee will be set based on the standard fees applicable to the services and provider(s) assigned unless otherwise stated or revised through the sliding scale (see below). The patient will either be placed on a treatment waitlist or begin working with a therapist at the earliest convenience. The patient and, when applicable, caregivers may also request referrals at any time during the treatment process if they are either not interested in waiting for services or do not feel our services are a fit. Boston Child Study Center encourages patients and their families to bring up any questions or concerns during the treatment process, as many issues can be problem solved effectively together. Patients and their families are free to withdraw from treatment at any time.

As a condition of receiving services with Boston Child Study Center, the patient's personal information will be stored confidentially HIPAA-compliant electronic medical record software. These databases may also be used for de-identified, retrospective research. Staff at BCSC are committed to developing and advancing effective educational and intervention procedures for patients and, where appropriate, reporting these findings to the professional community. BCSC occasionally uses data contained in a patient's file for archival research, quality assurance checks, and program development. This research is done in such a way that our patients cannot be identified or linked to the data used. If the data is used, it will be de-identified to protect the patient's anonymity and to keep personal records confidential. Information that may be used for research purposes may include details such as the patient's age, diagnosis, de-identified background information (e.g., developmental history, history of presenting concern), detailed course of treatment, and data collected through observation or questionnaires throughout the treatment process.

Policies and Fees:

Boston Child Study Center is an evidence-based, fee-for-service, faculty practice comprised of psychologists, neuropsychologists, social workers, mental health counselors, clinical psychology trainees, and trained support paraprofessionals. Typically, patients initially meet with a specialist in the area of concern for an initial consultation to determine a preliminary diagnosis, start to possibly identify underlying causes of symptoms presented, determine the appropriate level of care, and identify the best treatment team/program. Our Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Parent-Child Interaction Therapy (PCIT), and Individual-Intensive Outpatient Program for Complex Care (I-IOP) each offer a comprehensive team approach which may include a combination of evaluation, individual therapy, family therapy, exposure coaching, skills training/coaching, and/or parent coaching to address the patient's identified treatment goals. BCSC places a top priority on matching the patient's needs to the appropriate evidence-based treatment and may provide outside referrals if we determine that a better treatment match exists elsewhere.

Group policies: DBT Skills Training Groups require a 24-week commitment. Missing 4 groups will require an individual session to learn the missed group content and reestablish commitment prior to returning to group. DBT Skills Integration/ Anxiety/ Emotional Processing Groups require a 16-week commitment. Missing 3 groups will require an individual recommitment session prior to returning to group. DBT/CBT Skills Training and Skills Integration Groups for Parents require a 12-week commitment. Missing 3 groups will require an individual session to learn the missed group content and reestablish commitment prior to returning to group. New members are admitted to the groups on a rolling basis based on availability. Group members may have the opportunity to continue in group for additional time if treatment goals are established. Members of DBT Skills Training and Skills Integration Groups for Adolescents and Young Adults are required to be in ongoing individual DBT with skills coaching. Those in ongoing individual CBT may also be admitted to the group on a case by case basis. An intake session is required before starting any group. Patients or, when applicable, their legal guardian agree to inform group leaders of any changes in the patient's treatment team. Attendance policies and other group requirements may differ based on the specific group and will be communicated prior to starting in any group. Missed appointments or cancellations made less than 24-hours in advance are billed at the standard session rate, except for declared weather emergencies or documented medical emergencies.

BCSC's service rates are "fee-for-service" as we do not accept insurance. We offer a sliding scale which is granted on a need basis. If the patient wishes to apply for the sliding scale we request that families provide documentation of **total** family income for the parents regardless of age, the number of legal dependents that parents are financially responsible for and claim on the tax return, and current out-of-pocket monthly mental health expenses that are not reimbursed. After review of these documents, we will determine if the patient qualifies for an adjusted fee which the patient will then review before deciding whether to proceed with services. We also provide "insurance-friendly" statements that include many of the service codes and information the patient's insurance company may require in order to submit for "out-of-network" reimbursement. BCSC does not guarantee that any portion of the fees will be reimbursed by the patient's insurance provider. Patients are financially responsible for all services provided by BCSC staff and trainees regardless of the reason for a possible denial or reimbursement. Academic, didactic tutoring, and learning-based services that may augment the patient's overall treatment plan are not eligible for reimbursement by insurance companies. These services will appear on the monthly billing statement with a 00000 CPT code. While BCSC tries to provide patients with the information needed or requested by many insurance companies, we do not work directly with insurance companies nor do we enter into single case agreements. If appeals paperwork or communication is required, this time will be billed directly to the patient/ family and will not be covered by the insurance company. Telephone, email, completion of outside paperwork (i.e., paperwork requested for use outside BCSC such as: insurance company, school, etc.), travel, and video-conferencing consultation is billed at the patient's therapy services rate and is not reimbursable by the insurance company.

Payments are processed at the end of each month for the balance of the patient's account and can be paid by check, debit or credit card (Visa, MasterCard, Discover, Amex), or flex-spending debit card. BCSC requires that all clients provide a credit or debit card on file to be used as a primary method of payment. Financial information is stored and processed using PCI-compliant software. After the payment is processed the person responsible for billing will receive a statement via email unless another preference for receiving statements is specified, which will serve as the receipt of payment. If the patient or legal guardian would like to request a statement citing services rendered and/or the balance on the account prior to the end of the month, please do so in writing at any time by contacting Emily Hartson at EHartson@BostonChildStudyCenter.com.

Note: Missed appointments or cancellations made less than 24 hours in advance (except for snow or weather emergencies or documented medical emergencies) are billed at the standard treatment rate. A snow or weather emergency qualifies if the school district in which the patient resides is closed due to weather on the day of the scheduled appointment. Most standard treatment fees are listed below:

Sample of Standard Fees (lowest qualifying rate to full rate):

Initial Consultation: $15 - $900
Initial Psychiatry Consultation: $15 - $750
Comprehensive Neuropsychological Assessment: $2,100 - $6,500
Autism Diagnostic Observation Schedule (ADOS-2): $350 - $1,000
College Admissions Coaching Intake: $15 - $650
College Admissions Coaching: $15 - $280
Professional Training/Talk 1-3 Hours: $750 - $1,400
Professional Training/Talk 4+ Hours: $2,400 - $4,400
CBT/DBT Service Rate for Practice Directors: $15 - $450
Psychiatry Follow-Up Appointment: $15 - $600
Group Therapy Intake: $15 - $375
Group Therapy: $15 - $125
CBT/DBT Service Rate for Therapists: $15 - $375
Executive Functioning Coaching: $15 - $280

Confidentiality:

All clinical records are kept in a secure electronic medical record or secure filing cabinet. The information provided during the course of the patient's evaluation is confidential and will not be revealed outside of Boston Child Study Center without written permission, with a few exceptions that are described below:

1) Brief written summaries of each patient contact are required to be kept. These records could be subpoenaed by a court of law under certain conditions;
2) If your therapist has reason to believe that the patient or another child/elder/disabled person is being abused, or if the patient has any information regarding such abuse or neglect to another, the therapist is required by law to notify the appropriate child or adult protective agency;
3) If the therapist has reason to believe that the patient is at risk of making a serious and/or imminent attempt to hurt or kill themselves or someone else, the therapist is required by law to notify related emergency personnel or victims. In such cases we may be required to complete paperwork with the state involuntarily hospitalizing the patient;
4) If there is a criminal or civil legal action related to sanity or competence;
5) If the patient or legal guardian initiates legal action or ethical charges against Boston Child Study Center;
6) If the patient or legal guardian requests disclosure by signing a release of information form;
7) Sometimes children and adolescents may choose to share personal information with the therapist. Typically the specific content of the therapy sessions will not be shared with the legal guardian unless the patient agrees to it or unless it is necessary due to the patient evidencing imminent risk of harm to themselves or to others.

Tele-Health at BCSC

Telehealth is the provision of medical and/or mental health care services using technological modalities in lieu of, or in addition to, traditional face-to-face methods. BCSC utilizes tele-health as a method of delivering treatment services and may be used intermittently throughout the course of in-person therapy or as a primary method of treatment delivery. BCSC uses only HIPAA compliant platforms including but not limited to Google Meet and Zoom (healthcare versions).

I understand that, as in any online communication, there is a risk of loss of confidentiality. The web conferencing platforms being used for my care (Google Meet and Zoom) are HIPAA compliant and uses advanced data encryption technology to minimize the chance of loss of confidentiality. In addition to using a secure web conferencing platform, I understand that my therapist will only conduct sessions from a password-protected network, and that I have been encouraged to do the same.

Online Progress Monitoring at Boston Child Study Center

Through our commitment to providing the most innovative, evidence-based, compassionate, and complete care, the Boston Child Study Center (BCSC) has a partnership with Mirah Inc. to provide an online program that monitors how you (or your child, as applicable) is doing each week. This information allows our clinicians to respond with up-to-the-moment treatment refinements.

A variety of information may be collected through this platform, including: initial assessment information, weekly goals, and weekly or periodic symptom scales that your clinician feels are relevant to your care. Some of this information you may already be providing in paper format to your clinician, so online access will increase convenience for you. With this information, you and your clinician can make adjustments to care as needed. Your clinician can also review graphs indicating your progress with individual goals, skills mastered, or the presence of specific symptoms.

Twenty-four hours prior to your appointment time, you may receive a notification to complete a survey via smartphone or computer (usually taking 3-10 minutes). If you are unable to complete it prior to your appointment, it may also be filled out in the waiting room on our tablet or in your clinician's office during session.

This online measurement is operated by Mirah Inc. and, because we will be asking you questions about you or your child, one possible risk is privacy. This information, however, is treated as confidential and your data is kept in accordance with the Health Insurance Portability and Accountability Act (HIPAA), which provides for data privacy and security provisions. In addition, your data is encrypted and stored on secure servers by Mirah Inc. at all times.

Mirah Inc. will use information collected to support your provider and enhance quality assurance procedures at BCSC. Mirah Inc. and your clinical team are committed to advancing mental health care, so your data may be shared in an anonymized form (i.e., not linked to your identifying information) for research and operations purposes. You will not be personally identified in any reports or publications that may result from this survey.

Providing your consent for online progress monitoring is encouraged as it will assist in clinical care, however it is voluntary and a decision to not provide consent will not adversely affect your relationship with your clinician or the team at the Boston Child Study Center.

By signing this statement I am indicating that: 1) I have read this form in its entirety, 2) I have had questions or concerns regarding this form addressed by Boston Child Study Center Staff, 3) I fully understand all the information contained therein, particularly, the risks in online communications, 4) I am providing consent to enroll in online progress monitoring as described above.

Boston Child Study Center

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Emergencies:

Boston Child Study Center's clinical hours of practice are typically 10 am to 7 pm Monday through Thursday, and 10 am to 6 pm on Friday. If the patient's therapist is not available to immediately answer a call during those hours, he/she will do so as soon as possible during operating hours. Email should only be used for scheduling updates and not used to provide the therapist with clinical or personal information (as email is not a secure mode of communication), nor should email, text, or voicemail be used in emergencies. Boston Child Study Center staff has limited availability to respond to crisis situations (e.g., while working with another family, overnight, weekends, holidays, etc.) and for this reason it is crucial that patients are aware of other services available in the community in the event of a crisis or emergency. If the patient experiences a crisis or an emergency, call 911, go to a local emergency room, or call the Statewide Emergency Services Program at 877-382-1609. Upon arrival to the emergency room, the patient and/or caregiver can call the therapist to provide an update of the status of the emergency care (e.g., name of the hospital, name of provider at hospital, number where the patient can be reached) and BCSC will, at the earliest availability, get in touch with the patient and with the provider upon written or verbal consent for release of information. If the patient or therapist believes that the patient's well-being may be at risk due to limitations in the therapist's availability and/or crisis coverage, please let the provider know both in person and in writing and he/she will help find a more suitable option for providing care.

STATEMENT OF AGREEMENT:

By providing consent, I am indicating my understanding that the purposes of the initial consultation are to assess my current difficulties, help determine the best plan for addressing my or the patient's mental health needs, does not ensure that the patient will necessarily be assigned to work with a specific staff member of Boston Child Study Center, that Boston Child Study Center does not ensure that the patient's insurance provider will reimburse for the services rendered with Boston Child Study Center, and that the patient will be given referrals if it is determined that Boston Child Study Center is not a suitable match to address the patient's needs. I understand that if I have any questions about the evaluation, treatment, or its use, I may ask my therapist, Dr. Madigan, or Dr. Lambright about them at any time.

By signing this statement I am indicating that: 1) I have read Boston Child Study Center's Consent for services form in its entirety, 2) I have had any questions or concerns regarding this form addressed by Boston Child Study Center staff, 3) I fully understand all information contained therein, and 4) I freely agree that I may participate in the services offered.

_____

Name of Child (if applicable)

_____ _____

Name of Parent/Guardian/Self (if 18+) Signature of Parent/Guardian/Self (if 18+) Date

Please return this form to Boston Child Study Center either in person or by:
Email: AFlynn@BostonChildStudyCenter.com
Mail: Boston Child Study Center, 729 Boylston Street, 5th Floor, Boston, MA 02116
Fax: (866) 496-3029

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AUTHORIZATION FOR EXCHANGE OF INFORMATION

I, _____, authorize clinical communication between Boston Child Study Center staff and
(Parent, Guardian, or Self Name

Provider:	Name/Address:	Phone:
PCP/ Pediatrician	_____	(_____)_____
	_____	
Psychiatrist	_____	(_____)_____
	_____	
Individual Therapist	_____	(_____)_____
	_____	
Family Therapist	_____	(_____)_____
	_____	
School	_____	(_____)_____
	_____	
Other ( )	_____	(_____)_____
Other ( )	_____	(_____)_____

Communication may include any and all information in their possession acquired in the course of evaluation and/or treatment of the above named patient. In addition, I authorize the staff of Boston Child Study Center to share information with any emergency care givers who are involved in the patient's care in the event of a medical or psychiatric emergency. This authorization is voluntary and I have the right to refuse to sign it. I may revoke this authorization at any time by providing written notice of revocation; however, such revocation will not affect any action taken by Boston Child Study Center in compliance with this authorization before receipt of a written, hard-copy, revocation. I may accept photocopies or facsimiles of this authorization.

_____ _____

Signature of Parent/Guardian/Self (if 18+) Date Relationship to Patient

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Payment Authorization and Agreement

Boston Child Study Center requires all clients to provide a credit or debit card on file to be processed monthly in the amount due on your account. All credit or debit card information is stored in our electronic medical record, which maintains full HIPAA compliance as well as PCI compliance to ensure your personal and financial information is secure, respectively.

We are able to accept flex spending account cards however, if you choose to submit this form of payment you will also be required to submit a second payment authorization with a credit or debit card to be used in the event the flex spending account runs out of funds or is denied for any reason.

We also accept payment via check, which can be mailed or submitted to the front desk at the time of each of your appointments. If you submit payment via check and your account balance is zero at the end of each month your card on file would not be processed. If any remaining balance exists, your card on file will be processed for the outstanding balance.

Debit/Credit Card Authorization

Please complete the below fields to provide your debit card, credit card, or flex spending debit card to authorize the Boston Child Study Center, LLC to retain your card information on file and enroll your account in our monthly auto-payment system or as a backup payment if you choose to submit payments by check.

Card Type: Select

Cardholder's full name (as it appears on your card): _____

Card Number: _____ Exp: _____ Security Code: _____

Billing Address:_____ City: _____Zip:_____

Billing Phone: (_____) _____-_____ Email to send statement/receipt:_____

Authorization:

I hereby authorize the Boston Child Study Center to charge the indicated credit/debit card in the amount due on my account. I guarantee and warrant that I am the legal cardholder for this credit/debit card.

Signature_____ Printed Name:_____Date: _____